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September 19, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Re: HIP 2.0 1115 Waiver Application

Dear Administrator Tavenner:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Indiana's proposal to expand and modify the Healthy Indiana Plan (HIP) through the Section 1115 Demonstration Waiver process. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

We strongly support expanded access to Medicaid and appreciate Indiana's desire to pursue innovative approaches to the Medicaid program. Over 35,000 Hoosiers are expected to be diagnosed with cancer this year – many of whom will need to rely on Medicaid for affordable health care coverage. Our comments on the HIP 2.0 proposal are intended to ensure that cancer patients in Indiana will have adequate access and coverage under an expanded HIP program, and that specific requirements do not have the effect of creating barriers to care for low-income cancer patients. We hope Indiana and the Centers for Medicare and Medicaid Services (CMS) will come to a compromise that will ensure Hoosiers have access to quality, affordable, comprehensive health insurance.

Following are our specific comments on HIP 2.0.

POWER Account Contributions and Cost-Sharing

POWER Account Contributions

We are concerned that, as written, Indiana's proposal to implement a so-called "personal responsibility" approach to cost-sharing and POWER Account contributions may place a greater financial burden on the lowest income Hoosiers and may create barriers to individuals and families accessing needed health care.

Under Indiana's proposal, adults over 100 percent of the Federal Poverty Level (FPL) would pay a $25 monthly POWER Account contribution per person, which represents 2.5 percent of monthly income for an individual at 101 percent of the FPL. Adults below 100 percent of FPL who choose POWER Account

contributions rather than cost-sharing would face even greater burdens in some cases, with those at 23 percent of the FPL paying 3.6 percent of monthly income in POWER Account contributions and those at 51 percent of the FPL paying 3 percent of income. These examples are well above the Marketplace premium subsidy standard of 2 percent of income for an individual at 100 percent of the FPL and could create a serious barrier to care. **We recommend that CMS require POWER Account contributions be limited to no more than 2 percent of income.**

Lock-out periods
We are deeply concerned about the proposed lock-out period for those over 100 percent of the FPL who do not make their POWER account contributions. HIP 2.0 proposes a 6 month lock-out period after a 60-day grace period for non-payment of POWER account contributions. During the 6-month lock-out period, low-income cancer patients will likely have no access to health insurance, making it difficult or impossible to continue treatment. We applaud CMS' decision to reject lock-out periods most recently requested by the Commonwealth of Pennsylvania in the Healthy Pennsylvania Private Coverage Option Demonstration, and we believe the same approach should apply to Indiana's HIP 2.0 waiver request. **We strongly urge CMS to reject Indiana's request for a 6-month lock-out period for HIP 2.0 beneficiaries with income above 100 percent of the FPL who do not pay monthly POWER Account contributions.** Rather than impose lock-out periods – which can impede low-income cancer patients' access to treatment – we believe the only consequence for non-payment of POWER Account contributions should be disenrollment with the option to immediately re-enroll.

Copayments
We are also concerned about the level of copays required for those enrolled in the HIP Basic plan. For a patient with a serious, chronic condition such as cancer, copayments could quickly total 5 percent of income, which is a significant hardship for an individual or family fighting cancer. Cancer patients may also need a significant number of prescription drugs, and $4 to $8 per drug could pose a significant barrier to care if pharmacies are able to turn patients away for inability to pay. In addition, we are concerned that giving very low income patients the option to choose between POWER contributions and high copayments does not leave them with an option that will meet their needs. **We urge CMS to ensure that no HIP beneficiaries below 100 percent of the FPL will be turned away at the point of service for inability to pay a copayment. We also urge CMS to work with Indiana to lower copay requirements.**

Health Incentive Program
We are also concerned about the lack of specificity provided by Indiana on the Health Incentive Program, as health-contingent wellness programs can disadvantage cancer patients and others with chronic diseases due to physical circumstances beyond their control. **We recommend that CMS require Indiana to incorporate consumer protections similar to those described by the U.S. Department of Labor and Department of Health and Human Services (HHS) in the employer-based wellness program rules in any health incentive program.**

Eligibility

We are also concerned that Indiana's request to waive reasonable promptness, eligibility, and retroactive eligibility requirements to allow HIP Plus coverage to begin the month following an individual's first contribution to a POWER Account will unnecessarily delay coverage for eligible beneficiaries. Cancer can

be treated most effectively when it is detected early and treatment begins promptly. Delaying HIP Plus coverage for low-income populations, many of whom face other significant obstacles to receiving prompt and appropriate care, may lead to delays in cancer prevention and detection screenings, diagnosis, and/or treatment. **We therefore urge CMS to require Indiana to cover HIP Plus and HIP Basic enrollees as of the date of application, as required under the Medicaid program.**

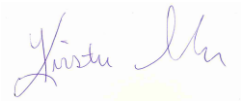
Benefits

Wrap-Around Benefits
After receiving a cancer diagnosis, one of the most difficult challenges that patients face is getting to and from treatment. It is often not advisable for patients to drive themselves home or use public transportation following a treatment. In addition, many cancer patients – particularly low-income cancer patients – do not own a vehicle, or do not live where public transportation is readily available to them. Some patients have no family members or friends to provide regular assistance with transportation. Without access to non-emergent transportation, cancer patients are often unable to get regular treatment, which reduces their chances of surviving cancer. **We urge CMS to require Indiana to provide non-emergent transportation as a wrap-around benefit for both HIP Plus and HIP Basic enrollees.**

Medically Frail
We appreciate Indiana's commitment to identifying and providing wrap-around services for the medically frail. However, we urge CMS to ensure that Indiana's proposal provides sufficient benefits and cost-sharing protections to enable this vulnerable population to access needed care. For example, it appears that those deemed medically frail will need to choose between POWER Account contribution and copayments (HIP Plus and HIP Basic, respectively), but will receive wrap-around benefits in either plan. As noted previously, we are deeply concerned that the cost-sharing required in the HIP Basic plan will pose a significant hardship for those diagnosed with cancer, particularly those deemed medically frail, and we are similarly concerned that POWER Account contributions exceed 2 percent of income for some individuals. **We request that CMS ensure that Indiana's approach to the medically frail population provides sufficient benefits and cost-sharing protections to ensure that cancer patients can continue treatment without interruption.** We also urge CMS to work with Indiana to ensure that Medicaid beneficiaries will be adequately educated about the differences between HIP Plus and HIP Basic, including likely differences in out-of-pocket costs.

We appreciate the opportunity to comment on the HIP 2.0 1115 Waiver Application. If you have any questions, please feel free to contact me or have your staff contact Anna Howard at anna.howard@cancer.org.

Sincerely,



Kirsten Sloan
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American Cancer Society Cancer Action Network